

Anatomy of the Hip Joint:

- **Bony contour:** 1-Anterior superior iliac spine (the most prominent bone anteriorly from iliac crest) 2-Pubic tubercle 3-Ischium 4-The Greater Trochanter
- **Two articulating surfaces:** *Proximally → Acetabulum *Distally → Head of the femur
- ****Dislocation is called Anterior or Posterior according to the Distal fragment**
- **Type of the Joint:** Ball & Socket
- **The Ligaments** are the structure that stabilizes the joint and keeps the posture
- **The Joint is enclosed by Capsule containing synovial fluid (السائل المزلق)**

Causes of Dislocation: 1- Traumatic 2- Non traumatic (Congenital / Pathological)

Types of dislocations: 1- Pure dislocation 2- Fracture dislocation (خلع + كسر)

According to: *Position of the limb *Severity of trauma *Continuity of trauma

a- Position of the Limb (in posterior dislocation)

- **Flexed Limb + Neutral position** neither abduction nor adduction) → head settles posterior on the capsule only so if trauma applied on the limb → rupture capsule but NO acetabulum fracture
- **Flexed + Adducted** → also no acetabulum fracture
- **Abduction** → Fracture of acetabulum

b- Severity of trauma: ↑ severity → ↑ Soft tissue damage

c- Continuity of trauma: → more dislocation and fracture

C/P: 1- Pain 2-Deformity 3-Limitation of all movements around the hip 4- Shortening
5- Head may be felt 6- Vascular sign (absent femoral pulsation)

Radiology:

Posterior dislocation: (90 %)

- Head away from the acetabulum, Limb is abducted, internally rotated, Shenton's line is interrupted

****Shenton's line:** Line between neck of femur and inferior border of superior pubic ramus

****Differentiate anterior from posterior by the appearance of lesser trochanter**

****Limb must be intact to comment on it (No fracture shaft of femur)**

***Fracture dislocation differs from pure dislocation in stability of joint, so you should test stability of joint after reduction. If there is acetabulum fracture → not stable → need open reduction and internal fixation**

Lines of Treatment:

**** TTT can be conservative up to 3 w unless there is sciatic nerve palsy or instability (dislocatable hip)**

Operative:

-Closed reduction:

- 1- General Anesthesia
- 2- Fix the pelvis
- 3- Flex hip and Knee in 90°
- 4- Apply progressively increasing traction to the extremity
- 5- Apply adduction with external rotation
- 6- Test the Stability
- 7- Put patient in hip spica for 6 weeks (ينطلون جبس)

Complications:

- 1- Avascular necrosis الموت اللاهوائي
- 2- Tear of sciatic Nerve
- 3- Myositis Ossificans
- 4-Osteoarthritis

